



State of New Hampshire
Board of Pharmacy
57 Regional Drive
Concord, NH 03301-8518
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

PHARMACIST ADMINISTRATION OF INFLUENZA VACCINES APPLICATION

ALL SECTIONS MUST BE COMPLETED.

PRINT CLEARLY IN BLACK OR BLUE INK ONLY. ILLEGIBLE, OUT-DATED, COPIED, OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

1. GENERAL INFORMATION

Applicant's Name		First	Middle	Last
Mailing Address				
City		State	Zip Code	Home Phone ()
Date of Birth (MM/DD/YY)		/ /		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	License Number		Are You <u>Currently</u> Certified By The Accreditation Council for Pharmacy Education (ACPE) to administer Influenza vaccines by injection?	<input type="checkbox"/> Yes* <i>*If Yes, you <u>must</u> attach a copy of your <u>current</u> ACPE Certificate.</i> <input type="checkbox"/> No
Do you possess at least \$1,000,000 of professional liability insurance?			<input type="checkbox"/> Yes* <input type="checkbox"/> No	<i>*If yes, you <u>must</u> attach a copy of the current certificate of insurance.</i>
Do you hold current basic or higher certification in cardiopulmonary resuscitation (CPR)?			<input type="checkbox"/> Yes* <input type="checkbox"/> No	<i>*If yes, you <u>must</u> attach a copy of the current certificate.</i>

2. CURRENT PHARMACY EMPLOYMENT

Name of Pharmacy	Date Of Hire As A Pharmacist (MM/YY)
	/
Complete Address of Pharmacy	

3. REGISTRATION

Are you now or have you ever been registered/licensed/authorized to administer influenza vaccines by injection in any other state? ☐ Yes* ☐ No
*If yes, indicate which state(s), and whether or not the registration/licensure/authorization is current. _____

4. LOCATIONS OF ADMINISTRATION

Please list all locations you intend to administer influenza vaccines at:

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

(Additional Sites may be listed on back)

5. APPLICANT'S STATEMENT

I certify that I am the person described and identified in this application; that I have read Ph 1300 of the NH Code of Administrative Rules, and that I have met the requirements for administering influenza vaccines; and that I have answered all questions truthfully and completely. Should I furnish any false or misleading information on this application, I hereby understand that such an act shall constitute cause for the denial or revocation of my registration as a pharmacist able to administer influenza vaccines by injection in the State of New Hampshire.

Signature: _____

Date: _____

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.
YOUR REGISTRATION CERTIFICATE WILL BE ISSUED WITHIN 2 WEEKS OF RECEIPT OF COMPLETED APPLICATION.
ONCE RECEIVED, YOUR CERTIFICATE MUST BE POSTED OR KEPT ON FILE AT YOUR PHARMACY
OF EMPLOYMENT & PRESENTED TO STATE PHARMACY INSPECTORS UPON REQUEST.